Information Summary and Recommendations

Optometrist Prescriptive Authority Sunrise Review

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Washington State Department of Health

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The Sunrise Review Process

Legislative Intent

It is the Legislature's intent to permit all qualified individuals to enter a health care profession. If there is an overwhelming need for the state to protect the public, then entry may be restricted. Where such a need to restrict entry and protect the public is identified, the regulation adopted should be set at the least restrictive level.

The Sunrise Act, RCW 18.120.010, states that a health care profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public and the potential for harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public can reasonably benefit from an assurance of initial and continuing professional ability; and
- The public cannot be protected by other more cost effective means.

After evaluating the criteria, if the legislature finds that it is necessary to regulate a health profession not previously regulated by law, the regulation should be consistent with the public interest and the least restrictive method. There are five types of regulation to be considered:

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions, and criminal prohibitions are not sufficient to eradicate existing harm.

2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business when a service is being performed for individuals involving a hazard to the public health, safety, or welfare.

3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practiced and, if required, a description of the service provided. A registrant could be subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

4. *Certification.* A voluntary process by which the state grants recognition to an individual who has met certain qualifications. Non-certified persons may perform the same tasks, but may not use "certified" in the title. A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to persons who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensee is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

Overview of Proceedings

The Department of Health notified the applicant group, all professional associations, board and committee chairs, and staff of the Sunrise Review. Meetings and discussions were held and documents circulated to all interested parties.

Regulatory agencies in all other states were requested to provide sunrise reviews, regulatory standards, or other information which would be useful in evaluating the proposal. A literature review was conducted. Staff have reviewed all submitted information and asked for feedback from interested parties.

An initial public meeting was held on June 24, 1996, to identify the relevant issues and key players. A public hearing was conducted on September 11, 1996. The hearing panel included staff from the Department of Health and a public member. Interested persons were allowed to give time limited presentations. There was an additional ten-day written comment period.

Following the public hearing and additional written comments, a recommendation was made based on all information received and in consultation with the public hearing panel. The proposed final draft was reviewed and approved by the Health Systems Quality Assurance Assistant Secretary and the Department Secretary. The final report was transmitted to the Legislature via the Office of Financial Management.

EXECUTIVE SUMMARY

In March, 1996, HB 2865 was forwarded to the Department of Health for sunrise review. The legislation allows optometrists to prescribe, use and administer drugs in any form, including controlled substances. Currently, optometrists may only use topical forms of optometric drugs for therapeutic and diagnostic purposes. The Board of Optometry would retain authority to develop rules outlining which specific drugs or drug categories may be used.

Optometrists may currently prescribe drugs only in topical form and only those that are for therapeutic or diagnostic purposes related to the vision system (as described in their scope of practice.) Optometrists must demonstrate successful completion of additional education to obtain a certificate allowing them to use this drug use or prescriptive authority.

FINDINGS

1. Optometrists have been using their current prescriptive authority (limited to topical agents for therapeutic and diagnostic purposes) safely and effectively. Experience in other states, including those with expanded prescriptive authority, indicate no rise in malpractice premiums nor disciplinary actions related to prescriptive authority.

2. Currently, if a patient has a problem for which a non-topical drug is needed, that patient must obtain a prescription from a physician, or nurse practitioner. If that prescriber is not immediately available, then delay occurs. The most common problems requiring a prescription beyond optometrists' authority are severe pain (often post-operative), and potentially dangerous infections. The need to administer dyes intravenously for diagnostic purposes has also presented problems for optometrists and their patients. As described by optometrists, in nearly all cases pain management is only needed for a few days.

3. Problems for the optometric patient range from having to obtain another provider to prescribe medicine, to the inconvenience of a delay, to severe pain, and even to the potential for loss of sight. The costs incurred from delay can be substantial, including payment to a second provider to obtain an evaluation and/or prescription, and travel cost and time. Delays which can cause extended pain and risk of long-term damage are exacerbated in rural areas.

4. The amount of training required under the applicant's proposal for optometrists to obtain the additional prescriptive authority appears more than adequate to meet the responsibility the expanded authority brings.

5. The lack of full prescriptive authority, in view of a full range of ocular problems presented by patients to optometrists, could be seen as limiting the optometrists ability to provide the competent, safe care that they are otherwise educated and trained to provide.

6. Although some controlled substances would rarely, if ever, be used in optometric practice, there seems to be no additional risk to the public from allowing optometrists access to them than for any other provider with prescriptive authority.

RECOMMENDATIONS

Options Considered:

In preparing this report, the review panel considered the following options:

Make no changes to current prescriptive authority.

Allow optometrists to use non-topical forms of drugs without limitations.

Allow optometrists to use non-topical forms of drugs, but limited to certain schedules of controlled substances, or with other limitations in statute.

If expanding prescriptive authority, allow the Board of Optometry to continue defining specifics of required training and listing of drugs in rule.

If expanding prescriptive authority, not allow the Board of Optometry to continue defining specifics of required training and listing of drugs in rule.

1. With the additions to the bill described below, pass HB 2865, allowing use of non-topical drugs and controlled substances.

A new paragraph (5) should be added to Section 1, as follows:

"(a) The prescription or administration of drugs, as authorized in this section, is specifically limited to those drugs necessary to treat diseases or conditions of the eye that are within the scope of practice of optometric physicians. The prescription or administration of drugs for any other purposes is not authorized by this section.

"(b) The Optometry Board should provide careful guidance in rule so that licensees and persons who may be filling their prescriptions have a clear understanding of which drugs and dosage forms are included in this authority."

"(c) No optometrist shall prescribe, dispense or administer a controlled substance for more than seven days in treating a particular patient for a single trauma, episode or condition."

Add to Page 7, Line 33, after an optometrist licensed under chapter 18.53 RCW.: "subject to any limitations in RCW 18.53.010."

Additional technical changes: On Page 3, line 5, and on page 7, line 33, after "18.53 RCW" insert who is certified by the optometry board under RCW 18.53.010"

CURRENT REGULATION AND PRACTICE

Optometrists may currently prescribed drugs only in topical form and only those that are for therapeutic or diagnostic purposes related to the vision system (as described in their scope of practice.) Optometrists must demonstrate successful completion of additional education to obtain a certificate allowing them to use this prescriptive authority.

Forty-eight states and the District of Columbia have granted optometrists prescriptive authority, including 29 that allow non-topical medications to some extent. Appendix A, provided by the applicant, summarizes these scopes. The state of North Carolina has had a statute similar to HB 2865 for over nineteen years.

PROPOSAL FOR SUNRISE REVIEW

In March, 1996, HB 2865 was forwarded to the Department of Health for sunrise review. The legislation allows optometrists to prescribe, use and administer drugs in any form, including controlled substances. Currently, optometrists may only use topical forms of drugs for therapeutic and diagnostic purposes. Drugs used are limited in both current law and the proposed revisions to those appropriate for optometric purposes. The Board of Optometry would retain authority to develop rules outlining which specific drugs or drug categories may be used. A demonstration of the level of training would be required, and the board would issue a certificate upon application.

The bill adds optometrists to the list of providers who may prescribe (actually a technical change as optometrists are defined as practitioners in RCW 69.49.010) and specifically allows them access to the full range of controlled substances under the Controlled Substances Act.

INITIAL PUBLIC MEETING

An initial public meeting was held on June 24, 1996, and attended by interested parties. The purpose of this meeting was to identify key stakeholders and valid issues. The applicant representatives explained their profession, the contents of the bill, and answered questions.

INFORMATION SUMMARY

Department staff and the hearing panel reviewed all documents received during the review process. In this "Summary of Information" section, the text is paraphrased or quoted by the department from all documentation received. It does not reflect the department's findings, which are found in a later section of this report. Complete documentation of these viewpoints is in the department's files and is disclosable to the public upon request.

Applicant Group (Washington Association of Optometric Physicians)
"The most fundamental question posed by the entire sunrise process is whether there is a risk to the public which warrants imposing regulations upon a particular class of health care provider. Washington Association of Optometric Physicians (WAOP) submits that there is a risk to the public posed by allowing any health care provider to use or prescribe legend drugs and controlled substances...this risk can never be eliminated entirely by regulation. Therefore, the options available to the legislature are to bar optometric physicians from the use of non-topical drugs entirely, or to regulate the use of such drugs by optometric physicians in much the same manner that the use of drugs by other providers is regulated. ...the only basis for barring optometric physicians from using non-topical drugs would be a conclusion that the potential risk to the public from such use outweighs any benefit the public might realize from it. ...WAOP submits that the answer to this question is clearly "no" and that regulation of optometric physicians' use of non-topical drugs is preferable to banning such use.

"The second [sunrise question] is whether the public needs and can reasonably be expected to benefit from regulations which assure that the providers being regulated have initially and continue to have the appropriate professional ability. With respect to this [application] there can be no doubt that the answer is "yes."

"The third [sunrise question] ...is really whether it will be more cost-effective to explicitly recognize the full prescriptive authority of optometric physicians, as the bill does, or to allow the current practices to continue. WAOP submits that the current system is woefully inefficient, and imposes substantial costs ...in terms of inferior care, inconvenience, delays in receiving treatment and higher costs. Therefore the bill will undoubtedly improve the cost-effectiveness of the health care system in Washington.

"During the hearing it became apparent that the opponents of the Bill either do not understand or are refusing to acknowledge two basic facts which have given rise to the need for this bill. First, for the great majority of patients needing oral or injectable medication for ophthalmic treatment, the first health care provider they see will be an optometric physicians. This is obvious, because optometric physicians are the primary eye care providers for the great majority of the population.

"Second, every patient who needs oral or injectable medication will get that medication, even if the optometric physician to whom the patient first presents is

unable to prescribe it... The entire discussion about the bill...has been about the costs and difficulties of locating a second practitioner to prescribe and, when necessary, administer medications. There has never been the slightest hint that optometric physicians are leaving patients untreated because they cannot prescribe the necessary medications themselves.

"The opponents of the bill argue strenuously that patients will be at greater risk if optometric physicians are given full prescriptive authority, but there is no factual basis whatsoever for this charge. It was clear from all of the testimony, including [that] of the opponents, that there are two sources of risk to the public...The first risk is potential error in diagnosis; the second is potential error in delivery of medication.

"...At the present time, the optometric physician does the diagnosis, and treats the condition with a topical medication or refers the patients on to another practitioner for additional treatment. In terms of the standards of professional conduct, and in terms of legal liability for failure to diagnose a condition, optometric physicians are held to the same standards as ophthalmologists and other medical doctors, and they have had comparable success. ...Dr. Sorom testified that he has "never" seen a patient who had been misdiagnosed by an optometric physician. ...

"It is true that, as a general rule, topical delivery is less dangerous than oral delivery, which in turn is less dangerous than delivery by injection. However, the risk is in the method of delivery, not in the degree which the person doing the delivery happens to have earned. ...We are not aware of any evidence showing that optometric physicians pose a greater danger to their patients than other professionals currently allowed to administer oral and injectable medications. Therefore, there is absolutely no reason for believing that there will be an increased risk to patients from allowing optometric physicians the full prescriptive authority the bill will grant.

[Because patients must receive many medications from a second provider, and that creates additional costs,] "it is important to focus on the nature of those additional costs to properly frame the issue involved. The issue is *not* whether optometric physicians or ophthalmologists charge more per visit. The issue is *not* whether the total costs of vision care provided by optometric physicians is greater or less than the total cost of vision care provided by ophthalmologists. The issue is simply whether it is possible to quantify the costs incurred by patients or the health care system in general when an optometric physician is required to involve a second practitioner....common sense tells us that when a second practitioner must be involved, costs are incurred and can be substantial.

"...The costs of delay...are an extended period of pain and in some cases a higher risk of unfavorable outcomes.

...[the arguments of the opponents to the bill] "are founded upon an attempt to avoid economic competition or upon logically inconsistent claims. Perhaps the best example of this is the remarks made at the hearing by Dr. Sorom. ...At one

point...[he] acknowledged that optometric physicians should have the authority to do an injection to treat anaphylactic shock. This concession obviously means [he] believes optometric physicians can be counted on to know when such an injection is necessary and can be trained to do the injection. ...[he] acknowledges that optometric physicians have not had any significant difficulties in the use of topical medication. ...Finally, [he] concedes that it might be useful to allow optometric physicians to prescribe up to 72 hours worth of pain medication. This concession obviously means that [he] believes optometric physicians know when and what to prescribe.

"...there are ...fallacies in the claims made by the opponents regarding education. [They] went on at length about the supposed inadequacies in the training of optometric physicians. However, they do not point to a single piece of evidence suggesting that the training optometric physicians receive is inadequate for the scope of practice of optometry. ...It is indisputable that medical doctors...have a far less restrictive scope of practice than do optometric physicians. Much of the training received by ophthalmologists is common to all medical physicians, ...However, there has been no showing, and there is no reason to believe, that all of that training is necessary or appropriate to the scope of practice of optometry. ...Optometric physicians have extensive education and training in pharmacology. ...Optometric physicians have established a track record of using those drugs without problem. ...Finally, everyone who has looked objectively at the education and training requirements involved in the bill has concluded that those requirements are more than adequate to protect the public.

"...the combination of the current requirement of 135 hours of pharmacology training and the additional 20 hours of training required by the bill will be more than adequate to guarantee the public that optometric physicians are fully competent to administer drugs topically, by injection, or orally. ...the total training which optometric physicians will receive is commensurate with the pharmacology training of ...dentistry and podiatry...There are many parallels among the professions of optometry, podiatry and dentistry, all of which require a bachelor's degree, followed by a minimum of four years of professional training.

"We submit that adoption of HB 2865 will improve patient access to prompt, high quality eye care. We are confident that adoption of the bill will reduce the cost to patients, and to the health care system in general, of eye care. We are confident that optometric physicians have more than enough training and education to use oral and injectable medications wisely. We are confident that optometric physicians are every bit as responsible, and every bit as concerned about the welfare of their patients, as any other health profession in Washington. For all of these reasons, we believe the public, and patients needing eye care, will be best served by adoption of HB 2865."

Beth Kneib, OD, Northwest Laser Center

"Some patients have needed general care, some have needed diagnostic care, and some have needed topical pharmaceutical care. All of which I could provide them. There are patients in my experience however, who have needed oral and injectable

medications which I could not provide. In these cases I had to find a secondary provider to help them with the care they needed. My patients and I have been lucky that I work in a setting where secondary providers are on hand to attend to their emergency needs. Other patients in Washington state have sometimes had to wait until a secondary provider could be located....these are the patients who have infections that have not responded to topical medications...these are patients with ocular inflammation that could threaten sight...these are patients with severe corneal abrasions with severe pain who need appropriate medications...these are the patients...who should never have to wait for a secondary provider when they need immediate attention.

"...we are professionals with four years of undergraduate education and four years of post graduate health care training. We are individuals who have proven beyond a doubt that we are capable and responsible in our use of topical pharmaceutical agents. ..."

Brett Bence, OD, Northwest Eye Center

He described the types of cases he sees that indicate a need to the additional prescriptive authority. He also summarized some of the education and training optometric physicians receive. "We are as disciplined, credentialled, and tested as any other health care profession." He identified pain management as an example of how the prescriptive authority meets patient needs. "Acute eye pain can be treated with eye drops, oral nonsteroidal anti-inflammatories, and narcotic analgesics. The short term use of these agents involves minimal dependency risk to the patient, provided a proper drug history is obtained and the appropriate dose administered."

"Many presentations of ocular infectious disease either may not respond to topical antibiotics, or require systemic therapy to increase drug concentration to the site of involvement.

..."Within the past year, a patient was seen for sudden loss of vision and pain behind an eye. She also reported jaw pain, a tender scalp, weight loss, and h ad been feeling ill the past few months. Her symptoms and clinical presentation of optic nerve swelling strongly suggested arteritic ischemic optic neuropathy and underlying temporal arteritis. ...In this case, treatment with oral corticosteroids needed to be started swiftly due to risk of blindness...the patient's physician and my associates were not immediately available. In my opinion, the time and effort it took to obtain the required oral medication placed the patient clearly at undue risk."

Mark Michael, OD, Mid-Columbia Eyecare Center

He presented three major points in considering the proposal. Is it good for patient care? Is there a need for the full prescriptive authority in everyday optometric practice? And has misinformation been supplied by the opposition? He believes the answer is "yes" to all three questions.

"For optometric physicians to have the right to provide systemic medications in the treatment of eye disease, by whatever route best indicated, is in the interest of best patient care. ...Optometric physicians are trained and educated to provide quality medical eye care to the public. In Washington and in other states where optometric physicians are treating the same ocular diseases as ophthalmology, we are achieving the same outcomes in treatment, without any adverse effects to public health or safety.

"...No one profession or class of people has a monopoly or a franchise on the education or training necessary to provide quality medical eye care, as the ophthalmologists claim they do."

Joseph Sifferman, OD, Roosevelt Vision Clinic
He described his 19 years of practice and explained his reasons why full prescriptive authority would provide safe, effective care to his patients. He described how delays in providing appropriate treatment may increase the risk of permanent ocular damage.

He and his two partners "have experienced the last minute patient who comes to our office after finishing work without an appointment, in order to have an ocular foreign body removed. ...excruciating pain [is felt] when topical anesthesia wears off in about fifteen minutes and stabbing pain returns. Selected use of oral analgesics would provide our patients short term relief from this type of intense pain.

Lesley L. Walls, MD, OD, Dean, College of Optometry, Pacific University, Oregon
He described his experiences as a practitioner of both medicine and optometry over a twenty-four year period.

"I have reviewed the pathology and pharmacology training in various other health care programs such as medicine, dentistry, podiatry, etc., and truly believe that the pathology and pharmacology training in the optometric physician curriculum equals that of other major health care professions.

...The optometric physician curriculum trains graduates in all aspects of topical, oral and injectable medications for ocular diseases. I truly believe that with proper education and training that it is safe. In many clinical situations it is safer, in my opinion, to use oral or injectable medications than topical. ...the key to using any of these medications is proper education and training which would include a plan for emergency care in case of an adverse reaction.

..."Our formal curriculum contains 144.5 clock hours of pharmacology training in didactic courses. However, there are dozens of hours of less formal pharmacology training which is covered during the process of patient care. ...I would, very conservatively, estimate this to be 200 or more hours. Additionally, in the ocular disease courses approximately 25% (67 clock hours) is pharmacology related.

...The current graduate of the [optometric] program and the practitioners who have met all the continuing education required by the licensing board, are properly educated and trained to use oral medications and injectable medications. This makes it very important for the various states to continually update the optometric physician practice acts in order to allow the practicing optometric physicians to utilize their education and training in the care of patients."

Anup K. Deol, OD, Member, Board of Optometry
She spoke representing herself, not the Board. She described her background and education.

"During my residency training, I had authority to prescribe all oral and topical ophthalmic medications [due to her residency being in a Veterans Administration hospital]. I also performed injections...Without any Ophthalmic Surgeons on staff, the VA hospital realized the cost-effectiveness in utilizing their competent Optometric Physicians to administer injections and allow full prescribing privileges.

"In my private practice...many occasions arise when an oral medication and/or injection is indicated. [Although I am] fully able to provide the appropriate treatment, I am forced to refer my patient to a second provider for these services. ...In my opinion, my patients deserve the best care, in a timely manner, at a reasonable cost."

Jay Haynie, OD, Retina and Macula Specialists
"I am now practicing in multi-disciplinary clinics in Tacoma and Renton. We provide tertiary eye care...we see more complicated and difficult cases than the average optometric physician. In this setting, I can say with conviction that I truly believe patients would be served in a more efficient, cost effective, and safe manner if I had the ability to prescribe the necessary non-topical medications.

"...my job is to provide appropriate consultations with [referring] doctors, and it is my job to return patients to referring doctors when their disease process has been stabilized. This is no different than the role played by a health care specialist of any kind, regardless of degree.

"...Based on my experience, I have reached conclusions which I believe are important...First, it is clear to me that complications from the use of drugs for ophthalmic purposes are rare, and serious complications are extremely rare. Second, it is clear to me that optometric physicians have the knowledge and training necessary to properly anticipate and respond to the few adverse consequences which do occur....Third, we are all in the position of following patients who are taking medications prescribed by other physicians. In this position it is incumbent upon us to understand the risk and benefits of these pharmaceutical agents.

"...The great majority of drugs which optometric physicians will use if this bill is passed are already known to us and being used topically. The only change will be the route of administration of the drug.

"...The purpose of the bill...is to complete the circle, as it were, allowing us to provide our patients a greater complement of care in a safe, cost-effective manner."

Cynthia Murrill, OD, MPH, Pacific Cataract and Laser Institute
"From a public health viewpoint, our society's goal is a healthy, productive population. This is accomplished by an effective and efficient health care system which protects citizens health, safety, and welfare. Public health dictates: competent providers; flexible, rational access; appropriate and effective treatment outcomes, and cost-effective care.

"...The enhancement of optometry's prescriptive authority should improve the quality of patient treatment, allowing alternative routes of administration of appropriate medications in a more timely fashion, speeding recovery and decreasing costs and time lost to the individual and to society. This certainly protects the public health, safety and welfare."

Washington Academy of Eye Physicians and Surgeons *(NOTE: the information quoted here is a summary which is part of a lengthier written statement provided to the review team.)*
"The training of physicians for the tasks they perform is part of an integrated regimen for medical practice. It is inappropriate and dangerous to tease out pieces of that training, attempting to graft them onto the training of an entirely different profession. To do this in order to justify optometrists assuming medical practice is illogical. Similarly, the hypothesis that conferring medical practice on optometry will reduce costs has been effectively refuted by empirical studies conducted by disinterested third parties. The countervailing assertions of optometrists are unsupported empirically.

"There is no public problem that this piece of legislation is meant to solve. There are, however, five legal-economic problems this will solve for optometrists.

"(1) Optometric scope of practice does not confer on optometrists the ability to diagnose and treat all eye disease. That authority is instead inferred from the remedies available to optometrists. By giving them full prescriptive authority, optometrists will be able to argue that they were given the same scope of practice as physicians...

"(2) The Optometry Board is under legal attack for a series of previous ruling permitting optometrists to perform medical and surgical tasks. They have concluded that it will be difficult to defend those ruling in court given the fact that the legislature has not given them full prescriptive authority. This request is meant

to assist the board to validate their previous board authorized expansions of scope of practice.

"(3) Optometrists want their board to define surgery as already within the scope of practice of optometry, and they likewise correctly believe that will be difficult to defend in court without full prescriptive authority.

"(4) The Optometrists generally do not bother with the sunrise process, preferring instead to go to their compliant board for a ruling whenever they want to expand their scope of practice. However, their statute expressly limits their prescriptive authority so, as to that function, they need legislative approval rather than simply seizing the new function as they usually do. The point of this request is nothing less than to provide optometrists the ostensible legal groundwork for their board to authorize the same scope of practice as physicians.

"(5) The failure to have full prescriptive authority jeopardizes co-management arrangements whereby optometrists and cooperating ophthalmologists avoid the anti-rebate laws that would otherwise prohibit ophthalmologists compensating optometrists for surgical referrals.

"Solving these legal problems for optometrists will enable their board to continue to expand their scope of practice without legislative or sunrise review and ward off lawsuits attacking that unlawful behavior. Therefore, this is not a public problem that justifies expanding their scope of practice under the sunrise statute's criteria.

"...prescribing drugs involves pharmacology, but pharmacology is a tool for maintaining eye health. However, a complete medical understanding of eye health and its connection to all other systems of the body of which it is a part is also critical. The pharmacology entails and requires a complete understanding of the human body, other diseases, and other drugs unrelated to vision pharmacopoeia and the like. If knowledge of pharmacology alone were all that was required for prescriptive authority, then pharmacists would have full prescriptive authority because their knowledge of the drugs is probably unsurpassed on the average among the professions....

"Pharmaceuticals that are not topical are therefore blood borne (irrespective of whether administered orally or intravenously). Whether they are aimed at the eye or not, they by definition affect all organs of the body. Any other drugs that are being taken raises the issue of drug interactions. ...Ocular drugs are used to treat cancer, arthritis, diabetes, hypertension, migraines and the like.

"Indeed there is an entire standard reference aimed at drug interactions and other drug induced ocular side effects that presumes a comprehensive understanding of the entire body and its various systems. The table of contents of that book... illustrate[s] the comprehensiveness of this issue. Yet we are asked to believe that a few hours of continuing education prepares a practitioner to cope with this.

"...By giving optometrists the entire medical armamentarium, their board will argue that the legislature is implicitly giving them the entire medical scope of practice of ophthalmology. That is what the effect of yielding to this proposal will be.

"...The hypothesis of the optometrists petition is that medical school is not really very important, teaches a lot of unnecessary material that is largely irrelevant to eye health, and that the part that is relevant to eye care can be duplicated with continuing education seminars. Based on the optometrists' petition, one wonders why we have medical schools. However, the excellence of medical education is only doubted by persons seeking the same scope of practice and who did not go. The public has no such illusion and trusts government to authorize only those with genuinely equivalent ability, training and skills to perform medical tasks. That is the responsibility to the public at issue...in this process. ...

"...ophthalmologists ...ask the sunrise process to maintain the distinction between medical school graduates and optometry school graduates that is so obvious in a detailed look at the two programs. We have no doubt that optometrists would be arguing the same thing if opticians were here today asserting similarly about the equivalency of their training to optometry training. ...No amount of manipulation of the facts...can obscure the fact that this petition represents an attack on the entire notion that medical school is a useful undertaking.

"...If cost is the issue, where are the carriers (who pay the bills for vision care) in support of or indeed initiating this proposal? In this day of health care cost containment and managed care, can anyone doubt that some companies would already have stepped forward on this issue, if their data supported it? ...

"The American Academy of Ophthalmology...has commissioned a distinguished neutral firm to look at some of these [cost] issues from an empirical point of view. A summary of the findings are presented here: (1) The total cost of the health care for specified conditions was more expensive when delivered by an optometrists than by an ophthalmologist....(2) The volume of visits and tests provided by optometrists in states with added prescriptive authority are twice as high as in states without such added prescriptive authority...(3) Expanding optometric scope of practice statutes will eventually increase the cost of eye care to the public, insurance carriers, and to state and federal governments. ...

"Optometrists go to some length to suggest that there have been no averse outcomes deriving from their previous extensions of scope of practice. We are attaching a review of malpractice cases for optometrists deriving from their previous authority to use diagnostic and therapeutic drugs. While we do not argue that the presence of malpractice means consistent substandard care, it does effectively refute the notion that everything has been trouble free.

"What then is the public health [problem] this [proposal] aims to fix? There is none. It did not originate with consumer groups. It did not originate with health care carriers who pay the bills for patients' vision care and believed that the current system resulted in egregious over-charging by ophthalmologists. Nor did it

originate as a result of some study of health care delivery by a neutral third party that identified this is a cause of documented maldistribution of health care resulting in increased morbidity. It originated with optometry as did the two previous drug bills just as virtually all licensing bills begin with the profession to be regulated.

"...There is currently a provision in the nurse practitioner act, the physicians assistant act, and the osteopathic physicians act providing that they could perform any medical tasks except those that coincided with the practice of optometry and some other professions. Would optometry back the repeal of that provision so that nurse practitioners and PAs could be trained for vision health tasks in the same way they are trained for other health tasks? ...

"...Vague and undocumented testimony by a dozen optometrists about how this would make things more convenient for their patients does not rise to a public health problem. In the face of optometry's continued indifference to patient convenience described below, that claim is simply not believable. ...To base the repeal of medical licensure in virtually the entire field of ophthalmology, premised on claims that the proponent almost certainly does not believe, is unwise and dangerous. To do so in the complete absence of any objective indications of a genuine public health problem, other than optometric manufactured testimony, would be unwise and at odds with the sunrise statute."

FINDINGS

1. Optometrists have been using their current prescriptive authority (limited to topical agents for therapeutic and diagnostic purposes) safely and effectively. No complaints have been received by the Department of Health related to this part of optometric practice. Experience in other states, including those with expanded prescriptive authority, indicate no rise in malpractice premiums nor disciplinary actions related to prescriptive authority. In North Carolina, which has had a broad prescriptive authority for nearly 19 years, only a handful of disciplinary cases have resulted from this authority. (NOTE: copies of letters from five states were provided; the one from North Carolina was most notable because of the length of time broad prescriptive authority has existed in that state. Of the 923 licensed optometrists, 864 have broad prescriptive authority. In 19 1/2 years, there have only been 18 complaints alleging improper use of pharmaceuticals or illegal practice of medicine; only a small portion of those resulted in disciplinary action.)

2. Currently, if a patient has a problem for which a non-topical drug is needed, that patient must obtain a prescription from a physician, or nurse practitioner. The optometrist who works in a group practice involving ophthalmologists can more easily obtain this prescription. If that prescriber is not immediately available, then delay occurs. Prescribers who do not know the optometrist may require that the patient see them before they issue a prescription. The most common problems requiring a prescription beyond optometrists' authority are severe pain (often post-operative), and potentially dangerous infections. As described by optometrists, in nearly all cases pain management is only needed for a few days. The need to administer dyes intravenously for diagnostic purposes has also presented problems for optometrists and their patients.

3. Problems for the optometric patient range from having to obtain another provider to prescribe medicine, to the inconvenience of a delay, to severe pain, and even to the potential for loss of sight. In all cases presented, however, proper care was received prior to any long-term damage. The pain involved in some problems that patients present to optometrists should not be underestimated, however. The costs incurred from delay can be substantial, including payment to a second provider to obtain an evaluation and/or prescription, and travel cost and time. Delays which can cause extended pain and risk of long-term damage are exacerbated in rural areas where there may be an optometrist but not an ophthalmologist, who are the most likely type of physician to deal with vision-related problems. (See Appendix D). The extent to which the additional prescriptive authority would have a measurable effect in rural areas greater than non-rural areas is not known.

4. The amount of training required under the applicant's proposal for optometrists to obtain the additional prescriptive authority exceeds the additional training advanced practice nurses must have to obtain prescriptive authority. This amount appears more than adequate to meet the responsibility expanded authority brings.

5. The lack of full prescriptive authority, in view of a full range of ocular problems presented by patients to optometrists, could be seen as limiting the optometrist's ability to provide the competent, safe care that they are otherwise educated and trained to provide.

6. Although some controlled substances would rarely, if ever, be used in optometric practice, there seems no additional risk to the public from allowing optometrists access to them than for any other provider with prescriptive authority.

RECOMMENDATIONS

Options Considered:
In preparing this report, the review panel considered the following options:

- Make no changes to current prescriptive authority.
- Allow optometrists to use non-topical forms of drugs without limitations.
- Allow optometrists to use non-topical forms of drugs, but limited to certain schedules of controlled substances, or with other limitations in statute.
- If expanding prescriptive authority, allow the Board of Optometry to continue defining specifics of required training and listing of drugs in rule.
- If expanding prescriptive authority, not allow the Board of Optometry to continue defining specifics of required training and listing of drugs in rule.

1. <u>With the additions as described below, pass HB 2865, allowing use of non-topical drugs and controlled substances.</u>

A new paragraph (5) should be added to Section 1, as follows:

"(a) The prescription or administration of drugs, as authorized in this section, is specifically limited to those drugs necessary to treat diseases or conditions of the eye that are within the scope of practice of optometrists. The prescription or administration of drugs for any other purposes is not authorized by this section.

"(b) The board should provide careful guidance in rule so that licensees and persons who may be filling their prescriptions have a clear understanding of which drugs and dosage forms are included in this authority."

"(c) No optometrist shall prescribe, dispense or administer a controlled substance for more than seven days in treating a particular patient for a single trauma, episode or condition."

Add to Page 7, Line 33, after an optometrist licensed under chapter 18.53 RCW,: "subject to any limitations in RCW 18.53.010,"

Additional technical changes: On Page 3, line 5, and on page 7, line 33, after "18.53 RCW" insert who is certified by the optometry board under RCW 18.53.010"

Rationale:

- There is a benefit to the public from reducing unnecessary regulation and allowing optometrists to utilize the full range of medically-necessary treatment for their patients. This ranges from reduced inconvenience and cost from delays, as well as pain management and prevention of potential long-term damage to vision.

- There is no evidence that optometrists are not properly trained for or have used their current prescriptive authority in anything but a responsible and safe manner, or that they would use expanded authority in anything but a responsible and safe manner. The optometric statute limits drugs used to those appropriate to optometric practice, placing a natural and reasonable limitation on optometrist prescriptive authority.

- While education requirements for the additional authority appear to be adequate to protect the public, limited experience and predicted standards of practice make restrictions, within the authorized scope of practice, appropriate.

- Most recent optometry school graduates already have the expanded education. Other optometrists would also have to demonstrate this level of education.

- The Board of Optometry is the appropriate regulatory body for implementing the statute and defining, through the rule making process, the specifics of the education requirements (based on the statute) and providing specifics on which drugs may be used.

- Additional wording in statute to clarify that the use of these drugs is only for optometric purposes will put forth legislative intent concerning the need to restrict the purposes for which these drugs might be used.

REBUTTAL STATEMENTS

An addition to this year's sunrise review process was a "rebuttal" period. During this time, participants could provide the department with a 300 word (maximum) statement for each recommendation with which they disagreed. If kept under the maximum number of words, submissions would not be edited.

Washington Association of Optometric Physicians

WAOP's only objection to the staff recommendation on [HB2865] is to the proposed seven-day limitation on controlled substances. There is no reason to believe optometric physicians are less responsible, or more likely to abuse or misuse controlled substances, than any other class of health care providers, yet no other profession with prescriptive authority is subjected to a comparable restriction. Moreover, an arbitrary limitation of this nature is neither necessary nor appropriate for any class of health care providers. Every grant of prescriptive authority is predicated on the assumption practitioners will exercise reasonable judgment. It makes no sense to trust practitioners to know when six or seven days of medicine is excessive yet assume optometric physicians will not know when eight days is too much.

We believe the seven-day limitation on controlled substances should be eliminated entirely. If the limitation is to be retained, we believe it should be revised because the proposed language is somewhat ambiguous. We suggest, "No optometric physician shall prescribe, dispense or administer a controlled substance for more than seven days in treating a particular patient for a single trauma, episode or condition."

Finally, if the limitation is to be retained it should be incorporated into you new proposed new paragraph (5) of Section 1 of the bill. As currently written, the staff recommendation is that the limitation be incorporated into the definition of "practitioner" in the controlled substances law, RCW 69.50.010(w)(1). We do not believe that is an appropriate place for it.

With the exception of the seven-day limitation, we concur in the staff recommendations. We also want to thank you and the rest of the panel for the courteous and professional manner in which you handled all of the proceedings.

Brett G. Bence, OD, TLC Northwest Eye

As noted in your recommendations regarding HB 2865, there is clinical utility for the use of pain management in optometry practice. However, I question the wisdom of limiting prescription controlled substances to seven days. Common presentations of corneal abrasion, recurrent erosion, and non-perforating corneal trauma are managed by optometric physicians and can produce sever pain. In these patients, if tissue-re-epithelialization is rapid, chronic therapy and extended pain relief are obviated. However, in special circumstances tissue recovery may be complex and delayed. Thus, while the short-term prescription of controlled substances will clearly serve most patients, it may not serve all patients. Let me clarify further.

Delayed wound healing in the elderly or immunosuppressed patient and larger, denuded surface defects could extend corneal recovery beyond seven days. Additionally, recurrent corneal epithliopathy -- an abnormal architectural bonding of the anterior cell layers of the cornea -- if sever, necessitates active clinical oversight and uninterrupted pain modulation that may well extend beyond one week. In my opinion, these patients should not be arbitrarily

subjected to rigid controlled substance guidelines if they have clinically objective evidence of persistent injury. In my 17 years of practice, I have witnessed several patients requiring pain management that followed such an unfortunate, protracted clinical course.

Thank you in advance for considering our concerns regarding the appropriateness of pain control in these exceptional, but factual presentations.

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APPENDIX A

OTHER STATES SUMMARY
(provided by applicant)

SUMMARY - DRUGS PRESCRIBED BY OPTOMETRISTS

STATE	Medications Used To Treat ALLERGIES	Medications Used To Treat INFECTIONS	Medications Used To Treat GLAUCOMA	Medications Used To Treat INFLAMMATION	ORAL Medications Used To Treat PAIN
Alabama	T-O	T-O	T-O	T-O	O
Alaska	T	T	T	T	
Arizona	T	T	T	T	
Arkansas	T	T	T	T	
California	T	T-O		T*	
Colorado	T-O	T-O	T-O	T	O
Connecticut	T-O	T-O	T-O	T	O
Delaware	T-O	T-O	T-O	T	O**
Florida	T	T	T	T	
Georgia	T	T	T	T	O
Guam	T-O	T-O	T-O	T-O	O
Hawaii	T	T		T	
Idaho	T-O	T-O	T-O	T-O	O
Illinois	T	T	T	T	O**
Indiana	T-O	T-O	T-O	T-O*	O**
Iowa	T-O	T-O	T-O	T	O
Kansas	T	T	T	T	
Kentucky	T-O	T-O	T-O	T-O	O
Louisiana	T-O	T-O	T	T	
Maine	T-O	T-O	T	T-O*	O
Maryland	T	T-O	T	T*	
Michigan	T	T		T	
Minnesota	T	T	T	T	
Mississippi	T	T	T	T	
Missouri	T-O	T-O	T-O	T-O	O
Montana	T	T		T	O
Nebraska	T-O	T-O		T-O*	O
Nevada	T	T-O		T	
New Hampshire	T-O	T-O		T*-O*	O
New Jersey	T	T	T	T	
New Mexico	T-O	T-O	T-O	T-O*	O
New York	T	T	T	T	
North Carolina	T-O	T-O	T-O	T-O	O
North Dakota	T-O	T-O		T	O**
Ohio	T-O	T-O	T-O	T	
Oklahoma	T-O	T-O	T-O	T-O	O
Oregon	T	T	T	T	
Rhode Island	T	T		T	
South Carolina	T-O	T-O	T-O	T	O
South Dakota	T	T	T	T	O
Tennessee	T-O	T-O	T-O	T-O	O
Texas	T	T		T	
Utah	T	T	T	T	O
Vermont	T	T		T	
Virginia	T	T	T	T	O
Washington	T	T	T	T	
West Virginia	T	T	T	T	
Wisconsin	T-O	T-O	T-O	T-O	O
Wyoming	T-O	T-O	T-O	T-O*	O

KEY: T = Topical Pharmaceutical Agents
O = Oral Pharmaceutical Agents
* = No steroids.
** = No controlled substances.

NOTE: The information contained in this chart (developed by James W. Andrews, O.D.) represents a summary, as of June 24, 1996, of the state optometry statutes/board regulations. In some states situations for drug utilization may vary. The letter "T" or "O" in many instances represents every drug available under a specific heading. For more complete information, please contact Sherry L. Cooper, Legal Research Assistant, at the American Optometric Association St. Louis office (800-365-2219, Ext. 266).

APPENDIX B

HOUSE BILL 2865

H-3995.3

HOUSE BILL 2865

State of Washington 54th Legislature 1996 Regular Session

By Representatives Dyer, Cody, Hymes, Sherstad, Casada, L. Thomas, Schoesler, Mastin, Cairnes, Hargrove, Murray, Quall, Hatfield, Radcliff, Tokuda, Conway, Boldt, Veloria, Chopp, Lisk, Scott, Morris, Sehlin, Clements, Skinner, Mulliken, Robertson, Romero, McMorris, Van Luven, Sheahan, Valle, Campbell, Talcott, Delvin, Koster, Goldsmith, Scheuerman, Hankins, Pelesky, Carrell, Lambert, Crouse, Chappell, Reams, D. Schmidt, Blanton, Buck, Regala, Honeyford, Sterk, Jacobsen, Grant, Kessler, Brumsickle, Cooke, Johnson, Huff, Brown, Costa, R. Fisher, B. Thomas, Ogden, Rust, Basich, Thompson, Fuhrman, D. Sommers, Poulsen, Stevens, Smith, Dickerson, Cole, Patterson, Mitchell, Linville, Chandler, Appelwick and Silver

Read first time 01/23/96. Referred to Committee on Health Care.

AN ACT Relating to authorizing optometrists to use and prescribe approved drugs for diagnostic or therapeutic purposes without limitation upon the methods of delivery in the practice of optometry; and amending RCW 18.53.010, 69.41.030, and 69.50.101.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 18.53.010 and 1989 c 36 s 1 are each amended to read as follows:

(1) The practice of optometry is defined as the examination of the human eye, the examination and ascertaining any defects of the human vision system and the analysis of the process of vision. The practice of optometry may include, but not necessarily be limited to, the following:

(a) The employment of any objective or subjective means or method including the use of drugs ((~~topically applied to the eye~~)) for diagnostic ((~~and~~)) or therapeutic purposes by those licensed under this chapter and who meet the requirements of subsections (2) and (3) of this section, and the use of any diagnostic instruments or devices for the examination or analysis of the human vision system, the measurement

of the powers or range of human vision, or the determination of the refractive powers of the human eye or its functions in general; and

(b) The prescription and fitting of lenses, prisms, therapeutic or refractive contact lenses and the adaption or adjustment of frames and lenses used in connection therewith; and

© The prescription and provision of visual therapy, therapeutic aids and other optical devices, and the treatment with ((~~topically applied~~)) drugs by those licensed under this chapter and who meet the requirements of subsections (2) and (3) of this section; and

(d) The ascertainment of the perceptive, neural, muscular or pathological condition of the visual system; and

(e) The adaptation of prosthetic eyes.

(2) Those persons using drugs for diagnostic purposes in the practice of optometry shall have a minimum of sixty hours of didactic and clinical instruction in general and ocular pharmacology as applied to optometry, and for administering topically applied drugs for therapeutic purposes, an additional minimum of seventy-five hours of didactic and clinical instruction, and for administering or prescribing for therapeutic purposes oral, injectable, or other recognized methods of using or prescribing drugs, an additional twenty hours of didactic and clinical instruction, as established by the board, and certification from an institution of higher learning, accredited by those agencies recognized by the United States office of education or the council on postsecondary accreditation to qualify for certification by the optometry board of Washington to use drugs for diagnostic and therapeutic purposes. Such course or courses shall be the fiscal responsibility of the participating and attending optometrist.

(3) The board shall establish a schedule of drugs for diagnostic and treatment purposes limited to the practice of optometry, and no person licensed pursuant to this chapter shall prescribe, dispense, purchase, possess, or administer drugs except as authorized and to the extent permitted by the board.

(4) The board shall develop a means of identification and verification of optometrists certified to use therapeutic drugs for the purpose of issuing prescriptions as authorized by this section.

Sec. 2. RCW 69.41.030 and 1994 sp.s. c 9 s 737 are each amended to read as follows:

It shall be unlawful for any person to sell, deliver, or possess any legend drug except upon the order or prescription of a physician under chapter 18.71 RCW, an osteopathic physician or an osteopathic physician and surgeon under chapter 18.57 RCW, an optometrist licensed under chapter 18.53 RCW, a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a commissioned medical or dental officer in the United States armed forces or public health service in the discharge of his or her official duties, a duly licensed physician or dentist employed by the veterans administration in the discharge of his or her official duties, a registered nurse or advanced registered nurse practitioner under chapter 18.79 RCW when authorized by the nursing care quality assurance commission, an osteopathic physician assistant under chapter 18.57A RCW when authorized by the board of osteopathic examiners, a physician assistant under chapter 18.71A RCW when authorized by the medical quality assurance commission, a physician licensed to practice medicine and surgery or a physician licensed to practice osteopathy and surgery, a dentist licensed to practice dentistry, a podiatric physician and surgeon licensed to practice podiatric medicine and surgery, or a veterinarian licensed to practice veterinary medicine, in any province of Canada which shares a common border with the state of Washington or in any state of the United States: PROVIDED, HOWEVER, That the above provisions shall not apply to sale, delivery, or possession by drug wholesalers or drug manufacturers, or their agents or employees, or to any practitioner acting within the scope of his or her license, or to a common or contract carrier or warehouseman, or any employee thereof, whose possession of any legend drug is in the usual course of business or employment: PROVIDED FURTHER, That nothing in this chapter or chapter 18.64 RCW shall prevent a family planning clinic that is under contract with the department of social and health services from selling, delivering, possessing, and dispensing commercially prepackaged oral contraceptives prescribed by authorized, licensed health care practitioners.

Sec. 3. RCW 69.50.101 and 1994 sp.s. c 9 s 739 are each amended to read as follows:

Unless the context clearly requires otherwise, definitions of terms shall be as indicated where used in this chapter:

(a) "Administer" means to apply a controlled substance, whether by injection, inhalation, ingestion, or any other means, directly to the body of a patient or research subject by:

(1) a practitioner authorized to prescribe (or, by the practitioner's authorized agent); or

(2) the patient or research subject at the direction and in the presence of the practitioner.

(b) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. It does not include a common or contract carrier, public warehouseperson, or employee of the carrier or warehouseperson.

© "Board" means the state board of pharmacy.

(d) "Controlled substance" means a drug, substance, or immediate precursor included in Schedules I through V as set forth in federal or state laws, or federal or board rules.

(e)(1) "Controlled substance analog" means a substance the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II and:

(I) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance included in Schedule I or II; or

(ii) with respect to a particular individual, that the individual represents or intends to have a stimulant, depressant, or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance included in Schedule I or II.

(2) The term does not include:

(I) a controlled substance;

(ii) a substance for which there is an approved new drug application;

(iii) a substance with respect to which an exemption is in effect for investigational use by a particular person under Section 505 of the federal Food, Drug and Cosmetic Act, 21 U.S.C. Sec. 355, to the extent conduct with respect to the substance is pursuant to the exemption; or

(iv) any substance to the extent not intended for human consumption before an exemption takes effect with respect to the substance.

(f) "Deliver" or "delivery," means the actual or constructive transfer from one person to another of a substance, whether or not there is an agency relationship.

(g) "Department" means the department of health.

(h) "Dispense" means the interpretation of a prescription or order for a controlled substance and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(I) "Dispenser" means a practitioner who dispenses.

(j) "Distribute" means to deliver other than by administering or dispensing a controlled substance.

(k) "Distributor" means a person who distributes.

(l) "Drug" means (1) a controlled substance recognized as a drug in the official United States pharmacopoeia/national formulary or the official homeopathic pharmacopoeia of the United States, or any supplement to them; (2) controlled substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in individuals or animals; (3) controlled substances (other than food) intended to affect the structure or any function of the body of individuals or animals; and (4) controlled substances intended for use as a component of any article specified in (1), (2), or (3) of this subsection. The term does not include devices or their components, parts, or accessories.

(m) "Drug enforcement administration" means the drug enforcement administration in the United States Department of Justice, or its successor agency.

(n) "Immediate precursor" means a substance:

(1) that the state board of pharmacy has found to be and by rule designates as being the principal compound commonly used, or produced primarily for use, in the manufacture of a controlled substance;

(2) that is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance; and

(3) the control of which is necessary to prevent, curtail, or limit the manufacture of the controlled substance.

(o) "Isomer" means an optical isomer, but in RCW 69.50.101(r)(5), 69.50.204(a) (12) and (34), and 69.50.206(a)(4), the term includes any geometrical isomer; in RCW 69.50.204(a) (8) and (42), and 69.50.210© the term includes any positional isomer; and in RCW 69.50.204(a)(35),

69.50.204(c), and 69.50.208(a) the term includes any positional or geometric isomer.

(p) "Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a controlled substance, either directly or indirectly or by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container. The term does not include the preparation, compounding, packaging, repackaging, labeling, or relabeling of a controlled substance:

(1) by a practitioner as an incident to the practitioner's administering or dispensing of a controlled substance in the course of the practitioner's professional practice; or

(2) by a practitioner, or by the practitioner's authorized agent under the practitioner's supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale.

(q) "Marijuana" or "marihuana" means all parts of the plant Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. The term does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination.

(r) "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium, opium derivative, and any derivative of opium or opium derivative, including their salts, isomers, and salts of isomers, whenever the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation. The term does not include the isoquinoline alkaloids of opium.

(2) Synthetic opiate and any derivative of synthetic opiate, including their isomers, esters, ethers, salts, and salts of isomers,

esters, and ethers, whenever the existence of the isomers, esters, ethers, and salts is possible within the specific chemical designation.

(3) Poppy straw and concentrate of poppy straw.

(4) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives or ecgonine or their salts have been removed.

(5) Cocaine, or any salt, isomer, or salt of isomer thereof.

(6) Cocaine base.

(7) Ecgonine, or any derivative, salt, isomer, or salt of isomer thereof.

(8) Any compound, mixture, or preparation containing any quantity of any substance referred to in subparagraphs (1) through (7).

(s) "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. The term includes opium, substances derived from opium (opium derivatives), and synthetic opiates. The term does not include, unless specifically designated as controlled under RCW 69.50.201, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). The term includes the racemic and levorotatory forms of dextromethorphan.

(t) "Opium poppy" means the plant of the species Papaver somniferum L., except its seeds.

(u) "Person" means individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

(v) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(w) "Practitioner" means:

(1) A physician under chapter 18.71 RCW, a physician assistant under chapter 18.71A RCW, an osteopathic physician and surgeon under chapter 18.57 RCW, <u>an optometrist licensed under chapter 18.53 RCW,</u> a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a registered nurse, advanced registered nurse practitioner, or licensed practical nurse under chapter 18.79 RCW, a pharmacist under chapter 18.64 RCW or a scientific investigator under this chapter, licensed, registered or otherwise permitted insofar as is consistent with those

licensing laws to distribute, dispense, conduct research with respect to or administer a controlled substance in the course of their professional practice or research in this state.

(2) A pharmacy, hospital or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state.

(3) A physician licensed to practice medicine and surgery, a physician licensed to practice osteopathy and surgery, a dentist licensed to practice dentistry, a podiatric physician and surgeon licensed to practice podiatric medicine and surgery, or a veterinarian licensed to practice veterinary medicine in any state of the United States.

(x) "Prescription" means an order for controlled substances issued by a practitioner duly authorized by law or rule in the state of Washington to prescribe controlled substances within the scope of his or her professional practice for a legitimate medical purpose.

(y) "Production" includes the manufacturing, planting, cultivating, growing, or harvesting of a controlled substance.

(z) "Secretary" means the secretary of health or the secretary's designee.

(aa) "State," unless the context otherwise requires, means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(bb) "Ultimate user" means an individual who lawfully possesses a controlled substance for the individual's own use or for the use of a member of the individual's household or for administering to an animal owned by the individual or by a member of the individual's household.

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APPENDIX C

APPLICANT CHECKLIST

APPLICANT CHECKLIST
WASHINGTON STATE DEPARTMENT OF HEALTH
SUNRISE REVIEW

Applicants are requested to complete this "checklist." It is designed to provide the legislature with basic information about the profession being reviewed. There may be questions not relevant to a particular applicant; in that case, just skip the question. The department staff will assist you in completing this form, as needed.

1. Legislative proposal being reviewed under the sunrise process (includes bill number if available:
   Optometrist Non-Topical Drug Sunrise Review HB 2865.

2. Applicant's organization: Washington Association of Optometric Physicians
   Address: 555 - 116th Ave. NE. Suite 166
   Bellevue, WA 98004-5274
   Contact person: Judy Balzer
   Telephone number: 206-455-0874
   Fax number: 206-646-9646
   E-mail address: waop@eyes-org

3. Number of members in the organization: 550
   Approximate number of individuals practicing in Washington: 750

4. Name(s) and address(es) of national organization(s) with which the state organization is affiliated:
   American Optometric Association, 243 Lindbergh Blvd, St Louis, MO 63141

   Name(s) of other state organizations representing the profession:
   None

5. Name and title of profession the applicant seeks to credential/institute change in scope of practice:

   The profession affected is the profession of optometry; the only practitioners affected are optometric physicians, O.D.s

APPENDIX D

RURAL AREA AVAILABILITY OF PROVIDERS

Rural Health Services

Shown below is a matrix which represents by zip code the rural areas in Washington State that are served by Optometrists, Ophthalmologists, or neither.

OD = Optometrist OPH = Ophthalmologist No entry = Zero

98010	98292 - 1 OD	98541	98617
98019	98293	98542	98619
98022 - 2 OD	98294	98544	98620 - 1 OD
98024	98297	98545	98621
98025	98304	98546	98623
98045 - 1 OD	98305	98547	98624
98050	98320	98548	98625
98051	98321	98550	98626 - 2 OD
98065	98323	98552	98628
98068	98324	98554	98631
98221 - 2 OD/2 OPH	98325	98555	98632 - 8 OD/3 OPH
98223 - 2 OD/1 OPH	98326	98557	98633
98224	98330	98559	98635
98232	98331	98560	98637
98233 - 2 OD	98334	98561	98638
98235	98336	98562	98640
98237	98339	98563	98641
98238	98343	98564	98643
98239 - 2 OPH	98350	98565	98644
98241 - 1 OD	98355	98566	98645
98243	98356 - 1 OD	98568	98647
98245 - 1 OD	98357	98569	98648
98246	98358	98570	98649
98249	98361	98571	98650
98250	98362 - 1 OD	98572	98651
98251	98363	98575	98670
98253	98365	98576	98672
98255	98368	98577 - 2 OD	98673
98256	98369	98579	98801 - 6 OD/5 OPH
98257	98376	98581	98802 - 2 OD
98259	98377	98582	98803
98261	98381	98583	98807 - 1 OPH
98263	98382	98584 - 1 OD/1 OPH	98811
98267	98385	98585	98812
98267	98396	98586	98813
98272 - 1 OD	98397	98587	98814
98273 - 4 OD	98520 - 3 OD/2 OPH	98589	98815 - 1 OD
98274	98521	98590	98816 - 2 OD
98277 - 2 OD	98522	98591	98817
98278	98526	98592	98819
98279	98527	98593	98821
98280	98530	98595	98822
98283	98531	98596	98823
98284 - 3 OD/1 OPH	98532 - 6 OD/3 OPH	98602	98824
98285	98533	98605 - 1 OD	98826
98286	98535	98609	98827
98287	98536	98610	98828
98287	98537	98611	98829
98288	98538	98612	98830
98290 - 1 OD	98539	98613	98831
98291	98540	98614	98832

SOURCE: Health Personnel Resource Plan Database

98833	99101	99174	
98834	99102	99176	
98836	99103	99179	
98837 - 4 OD/3 OPH	99104	99180	
98838	99105	99181	
98840	99107	99185	
98841 - 1 OD	99109	99195	
98843	99110	99277	
98844	99111 - 1 OD	99321	
98845	99112	99324	
98846	99113	99326	
98847	99114 - 2 OD	99327	
98848 - 2 OD	99115	99328	
98849	99116	99329	
98850	99117	99332	
98851	99118	99332	
98852	99119	99333	
98853	99121	99341	
98855	99122	99343	
98856	99123	99344	
98857	99124	99345	
98858	99125	99347	
98859	99126	99348	
98860	99128	99350	
98862	99129	99356	
98920	99130	99357	
98921	99131	99359	
98922	99133 - 1 OD	99360	
98925	99134	99361	
98926 - 2 OD/1 OPH	99135	99362	
98930	99136	99363	
98932	99137	99371	
98933	99138	99401	
98934	99139	99402	
98935	99140	99403	
98938	99141 - 1 OD		
98939	99143		
98940	99144		
98941	99146		
98943	99147		
98944 - 3 OD	99148		
98946	99150		
98948	99151		
98949	99152		
98950	99153		
98951	99154		
98952	99155		
98953	99156		
98954	99157		
99006 - 1 OD	99158		
99007	99159		
99008	99160		
99009	99161		
99010	99163 - 4 OD		
99013	99164		
99017	99165		
99029	99166		
99032	99167		
99033	99169		
99034	99171		
99040	99173		

SOURCE: Health Personnel Resource Plan Database